STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155206	A. BUILDING 00 B. WING	06/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNSBURG HEALTH CARE CENTER	1010 HORNADAY ROAD BROWNSBURG, IN46112

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F0000	This visit was for the investigation of complaint IN00091302. Complaint number IN00091302: Substantiated, Federal/State deficiencies related to the allegations are cited at F279 and F323 Survey dates: June 23 and 24, 2011 Facility number: 000113 Provider number: 155206 This visit was for the Investigation of complaint IN00091302. AIM number: 100287670 Survey team: Vanda Phelps, R.N. Census bed type: 3 SNF 126 SNF/NF 129 Total Census payor type: 21 Medicare 87 Medicaid 21 Other 129 Total Sample: 5 These deficiencies also reflect state	F0000	Submission of this Plan of Correction shall not constitute or be construed as an admission by Brownsburg Health Care Center that the allegations contained in the survey report are accurate or reflect accurately the provisions of Nursing Care and Service to the residents of Brownsburg Health Care Center.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	findings cited in accordance with 410 IAC 16.2. Quality review completed 6/27/11 Cathy Emswiller RN			
F0279 SS=D	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on record review and interview, the facility failed to develop a plan of care which accurately guided certified nurse aides to deliver appropriate care to 1 of 5 residents reviewed for plans of care in the survey sample of 5. This contributed to causing Resident G to experience two fractures during a transfer. (Resident G) Findings include:	F0279	What corrective actions will be accomplished for those residents found to be affected by the deficient practice?It is the policy of the facility that every resident has a care plan which accurately guides the care of the resident that is accessible by both nurses and C.N.A.'s.Resident G is a 68 year old resident who sustained a left mid clavicular fracture and a left humeral neck fracture. He was in the stand up lift and being cleaned when he stated he	06/27/2011

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	On 6/23/11, during the orientation tour at 10:30 a.m., Unit Manager #2 indicated Resident G had fractured his clavicle/collarbone while being transferred out of bed with a stand-up lift. Review of Resident G's clinical record was completed on 6/24/11 at 12:05 p.m. His diagnoses included, but were not limited to, history of stroke, hemiplegia, osteoporosis and osteoarthritis. He had been hospitalized 5/29 to 6/1/11 for repair of a fractured clavicle and humerus (upper arm). His 6/8/11 five-day Resident Assessment Instrument indicated he was completely alert and oriented and his speech was clear. It indicated he was dependent on staff for all care except eating and had transferred only twice within the 7-day assessment period. To be noted, Resident G's weight was 284 pounds. During interview with Resident G on 6/24/11 at 12 noon, he said, "Two aides had me in a contraption and I couldn't hold on. I kept telling them, but they just kept telling me to hold on. Well, I couldn't--it was hurting too much and I'm not so strong anymore. I leaned toward the chair and that's when the bad pain started." He also stated, "I haven't been able to stand up on my legs for a long time--since the stroke."		couldn't be up any longer. His knees buckled and he sat in the sling. When moved to a chair he complained of left arm and chest pain and was evaluated and sent to ER. The hospital x-ray report showed no signs of traumatic fracture and noted bones were osteopenic. Resident did not complain of any pain until was placed in the chair.The only resident affected by the practice is resident G. All residents requiring assistance with transfers will be assessed by the DON and Therapy Director for the ability to use the stand-up lift. All care plans and aide assignment sheets will be updated to reflect any changes in tranfer techniques. Residents who require assistance with transfers will be reviewed in the weekly SWAT meeting with the DON & Therapy Director in attendance and the care plan and aide assignment sheets will be updated to reflect any changes. Evaluations are ongoing and will also be done on new admissions who require assist with transfer by the Therapy Director and DON. C.N.A.'s #1 & #2 as well as the Unit Manager have received disciplinary action and inservicing in regards to the transfer and use of the lift. His current care plan and aide assignment sheet state to use the hoyer lift.Aides are able to access the care plans in the charts with the nurses whenever they want to look at them.How will	

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	Interview of Certified Nurse Aide #1 on 6/24/11 at 2:20 p.m. indicated she answered Resident G's call light to find he had raised the head of his bed to a 90 degree angle and it had stuck there. But, due to an involuntary stool, he needed incontinence care immediately and it could not be accomplished in his bed as usual. She said she and another CNA "thought and thought" about it and decided to lift him in the stand-up lift and wash him while he was there. She indicated she and CNA #2 had not conferred with the charge nurse before making this decision. She indicated they had used the stand-up lift before for transfers and he'd done OK. She also indicated the CNA assignment/information sheets at that time indicated both that he could not bear weight and to use the stand-up lift for transfers. CNA #1 indicated Resident G was moaning and telling them he couldn't hold on anymore. She indicated they knew he could do it because he'd done it before. He used his arms and shoulders to hold himself up. She indicated all at once he just couldn't hold on and let loose, slumped downwards and started screaming to send him to the hospital. Review of a copy of the 5/24/11 CNA assignment/information list, which was in		other residents affected by the same deficient practice be identified and what corrective actions will be taken?All residents requiring assistance with transfer have the potential to be affected by the practice. Staff inservicing on the stand-up lift and transfers was done on 6/2/11 and is on-going. The stand-up lift is not to be utilized with a resident until the Therapy Director and DON have assesssed the resident and approved its use. Residents who require assistance with transfers will be reveiwed weekly in the facility SWAT meeting with the Therapy Director and DON in attendance. Care plans and aide assignment sheets will be updated for any changes.What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur?Staff inservicing was done on 6/2/11 and is ongoing on the use of the stand-up lift and transfers. Transfers will be reviewed weekly in the facility SWAT meeting with the Therapy Director and DON present.Care plans and aide assignment sheets will be updated with any changes.How will the corrective actions be monitored to ensure the deficient practice does not recur, ie, what quality assurance program will be put into place and the completion date?The Therapy Director and DON will review all transfers in the weekly facility SWAT meeting	

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	effect on 5/31/11, indicated "does not bear weight...Uses stand up lift for transfers...." Review of the current care plan indicated it addressed the issue of fall risk. The entry was dated as initiated on 7/27/2010 and was printed with hand written interventions added. One of the hand written interventions was dated 11/19/11: "hoyer lift transfer-use 2 people." Interview with the Director of Nursing 6/24/11 at 1:45 p.m. indicated she was aware the nurse aide assignment/information sheet which was in effect on 5/29/11 did indicate both pieces of information: Resident G could not bear weight and to use the stand-up lift for transfers. She agreed this was contradictory and had become aware of it only after this event occurred. She had tried to explain how unacceptable this was, but staff "kept repeating" to her that 'he could do it...he did it before..he just didn't want to." Review of the current nurse aide assignment/information sheet for Resident G indicated it did state he could not bear weight, but it did not direct staff as to how to transfer him. CNAs were not allowed to review the charts where the full care plan was maintained. This federal tag relates to complaint number IN00091302.		and also on all new admissions, Care plans and aide assignment sheets will be updated with changes. Any continued concerns will be addressed in the monthly Quality Assurance meeting via a written action plan. The plan will be monitored by the Administrator/DON/designee until resolution occurs.Currently there are no residents utilizing the stand up lift in the facility.	

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	3.1-35(d)(1) 3.1-35(d)(2)			
F0323 SS=G	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review and interview, the facility failed to ensure the safety of 1 of 5 residents reviewed for accidents in the sample of 5 in that, although he was assessed as unable to bear weight, he was transferred via a stand-up lift per instructions on the nurse aide information sheet which were in conflict with the official care plan of record. This resulted in fractures of his upper arm and collarbone. (Resident G) Findings include: During the orientation tour of 6/23/11 at 10:30 a.m., Unit Manager #2 indicated Resident G had fractured his clavicle/collarbone while being transferred out of bed with a stand-up lift. She indicated he also had left hemiplegia and was full care. She indicated he was interviewable but it would be extremely difficult because he spoke a Slavic language.	F0323	What corrective actions will be accomplished for the residents found to be affected by the deficient practice?It is the policy of the facility to ensure the safety of residents at all times.Resident G is a 68 year old resident who sustained a left mid clavicular fracture and a left humeral neck fracture. He was in the stand-up lift and being cleaned up when he stated he couldn't stand any longer. His knees buckled and he sat in the sling. He was then moved to a chair where he complained of left arm and chest pain. He was evaluated and sent to the ER. Resident did not complain of any pain until he was placed in the chair. The hospital x-ray showed no signs of traumatic fracture and noted that the bones were osteopenic.The only resident affected by the practice is resident G. All residents (including new admissions) requiring assistance with transfer will be assessed by the Therapy Director and DON for	06/27/2011

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	Review of Resident G's clinical record was completed on 6/24/11 at 12:05 p.m. His diagnoses included, but were not limited to, history of stroke, hemiplegia, osteoporosis and osteoarthritis. His 6/8/11 five-day Resident Assessment Instrument indicated he was completely alert and oriented and his speech was clear. It indicated he was dependent on staff for all care except eating and had transferred only twice within the 7-day assessment period. To be noted, Resident G's weight was 284 pounds. The nursing note on Sunday 5/29/11 at 4:15 p.m. indicated Resident G "...screaming stating, 'I want to go to the hospital. L (left) shoulder and L chest pain.' (sic)" The M.D. service was notified and responded at 4:40 p.m. Resident G was transferred via ambulance to the emergency room at 5:30 p.m. where he was subsequently admitted to treat fractures of his clavicle and humerus. During interview with Resident G on 6/24/11 at 12 noon, he said, "Two aides had me in a contraption and I couldn't hold on. I kept telling them, but they just kept telling me to hold on. Well, I couldn't--it was hurting too much and I'm not so strong anymore. I leaned toward the chair and that's when the bad pain		ability to use the stand-up lift. All care plans and aide assignment sheets will be updated with changes. Residents requiring assistance with transfers wil be evaluated in the facility weekly SWAT meeting with the Therapy Director and DON in attendance. Assignment sheets and care plans will be updated with changes. C.N.A.'s #1 & #2 as well as the unit manager have received disciplinary action and inservicing in regards to transfers and the use of the stand-up lift. Resident G's current care plan and assignment sheet state to use a hoyer lift for transfer. Currently there are no residents utilizing the stand up lift in the faclity.How will other residents affected by the same practice be identified and what corrective actions will be taken?All residents requiring asistance with transfer have the potential to be affected by the practice. Staff inservicing on the stand-up lift and transfers wa done on 6/2/11 and is ongoing. The stand-up lift is not to be utilized with a resident until the Therapy Director and DON have assessed the resident and approved its use. Residents who require assistance with transfers will be reviewed in the facility weekly SWAT meeting with the Therapy Director and DON in attendance. The care plans and aide assignment sheets will be updated with any changes.What measures will be put into place	

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	started." He also stated, "I haven't been able to stand up on my legs for a long time--since the stroke." Interview of Certified Nurse Aide #1 on 6/24/11 at 2:20 p.m. indicated she answered Resident G's call light to find he had raised the head of his bed to a 90 degree angle and it had stuck there. The resident had an involuntary stool and needed incontinence care, but they couldn't do it with his bed in that position. "We thought and thought and thought and decided to put him in the stand-up lift and clean him there...He agreed to it...He'd been using the stand-up for transfers to and from the wheelchair. He could do it. He used his arms and shoulders." She indicated she didn't see a difference between holding himself on the stand-up for a few seconds during a regular transfer and the several minutes it would take to clean him of an involuntary stool. She indicated they had decided against using the unoccupied bed in the room or other options. She indicated, "He was moaning and telling us he couldn't hold on, but we knew he could do it. We told him we were almost done and he kept saying he couldn't hold on anymore and then he just let go...He could have done it but he didn't want to...He'd been doing just fine." She indicated she and CNA #2 had not conferred with the charge nurse before		and what systemic changes will be made to ensure the deficient practice does not recur?Staff inservicing was done on 6/2/11 and is ongoing on the use of the stand-up lift and transfers. Transfers will be reviewed weekly in the facility SWAT meeting with the Therapy Director and DON in attendance. Care plans and aide assignment sheets will be updated with any changes.How will the corrective actions be monitored to ensure the deficient practice does not recur, ie, what quality assurance program will be put into place and the completion date?The Therapy Director and DON will review all transfers in the weekly facility SWAT meeting and also on all new admissions. Care plans and aide assignment sheets will be updated with changes. Any continued concerns will be addresses in the monthly quality assurance meeting via a written action plan. The plan will be monitored by the Administrator/DON/designee until resolution occurs.	

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	making this decision. She indicated the nurse aide information/assignment sheets said to use the stand-up lift. She indicated Resident G had not fallen, only slumped down in the straps of the lift leaning toward the bedside chair. Interview with the Director of Nursing 6/24/11 at 1:45 p.m. indicated she was now aware the nurse aide assignment/information sheet which was in effect on 5/29/11 did indicate both pieces of information: Resident G could not bear weight and to use the stand-up lift for transfers. She agreed this was contradictory and had become aware of it only after this event occurred. She had tried to explain how unacceptable this was, but staff "kept repeating" to her that "he could do it...he did it before..he just didn't want to." Review of the current nurse aide assignment/information sheet for Resident G indicated it did state he could not bear weight, but it did not direct staff as to how to transfer him. The current care plan addressed the issue of fall risk and indicated with an intervention added 4/19/11 as "hoyer lift transfer-use 2 people." This federal tag relates to complaint number IN00091302.			

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	3.1-45(a)(1)			